U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 25 April 2007

In the Matter of

C.A.S.
Claimant

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-In-Interest

Case No. 2004-BLA-05847

Appearances: C.A.S., Pro Se[1]

William S. Mattingly, Esq.
Jackson Kelly, P.L.L.C.
For the Employer

Before: William S. Colwell
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. The Act and applicable implementing regulations, 20 CFR Parts 718 and 725, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2004). In this case, the Claimant alleges that he is totally disabled by pneumoconiosis.

[1] Claimant's wife assisted Claimant at the hearing because, as she explained, he has suffered electrocution twice, and it has caused memory loss and confusion. Tr. 7.

I conducted a hearing on this claim on January 20, 2006 in Beckley, West Virginia. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2004). At the hearing, Director's Exhibits ("DX") 1-32, Administrative Law Judge Exhibits ("ALJX") 1-2, Claimant's Exhibit ("CX") 1, and Employer's Exhibits ("EX") 1-2 and 4-5 were admitted into evidence without objection. Transcript ("Tr.") at 18, 4, 17, 24, 29. EX 3 was not admitted into the record, because it is an x-ray reading that exceeds the evidentiary limitations, and good cause was not shown as to why it should be admitted. Employer filed written closing arguments March 24, 2006. The record is now closed.

In reaching my decision, I have reviewed and considered the entire record pertaining to the claim before me, including all exhibits admitted into evidence, the testimony at hearing, and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim for benefits on November 29, 1976. DX 1. It was denied by a Department of Labor claims examiner on March 7, 1980, for failure to establish any element of entitlement.

Claimant filed a second claim on July 15, 1985. DX 2. The claim was dismissed pursuant to an April 7, 1992 Order of Dismissal rendered by Administrative Law Judge James Guill. The dismissal was based on Claimant's failure to comply with an order to submit a medical release to, and answer interrogatories posed by, the Employer.

Claimant filed a third claim on September 3, 1996. DX 3. That duplicate claim was denied by Administrative Law Judge John C. Holmes in a Decision and Order Denying Benefits dated August 22, 2000. Judge Holmes found that Claimant worked in excess of 15 years of coal mine employment. He considered all the medical evidence of record, dating from January 18, 1977 through December 7, 1999. He found that Claimant failed to establish the existence of pneumoconiosis and a totally disabling respiratory impairment.

The record shows that no further action was taken until the current claim was filed on September 19, 2001. DX 5. Because it was filed more than one year after the previous denial, it is a subsequent claim governed by § 725.309(d). The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on October 28, 2003, on the grounds that the evidence did not show that the Claimant established the existence of pneumoconiosis or a totally disabling respiratory impairment. DX 23. The Claimant timely appealed that determination, and the case was referred to this office on February 19, 2004. DX 29.

APPLICABLE STANDARDS

Since this claim was filed after January 19, 2001, the current regulations at 20 CFR Parts 718 and 725 apply. 20 CFR §§ 718.2 and 725.2 (2004). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose at least in part out of his coal mine employment, that he is totally disabled, and that the pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2004).

ISSUES

After the hearing, the following are the remaining contested issues:

1. Whether the miner has pneumoconiosis as defined by the Act and the regulations.

2. Whether his pneumoconiosis arose out of coal mine employment.

3. Whether he is totally disabled.

4. Whether his total disability is due to pneumoconiosis.

5. Whether he has demonstrated that one of the applicable conditions of entitlement has changed since the date upon which the prior claim was denied.

DX 29; Tr. 13. (Employer conceded that Claimant has one dependent and stipulated to at least three years of coal mine employment with Westmoreland Coal Company. Tr. 13. Constitutional issues were preserved for appeal.)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Claimant and his wife testified to the following. Tr. 30-64. Claimant was born October 18, 1949 and was 56 years old at the time of the hearing. He never got past first grade, because he had to help his father work. He cannot read or write. He and his wife have been married for 34 years and have two grown children. One daughter has a plate in her head and has three children. Claimant testified that they "kind of draw on me." His other daughter lives next door to him, and he generally pays her house payments and does what he can "to keep my grandkids alive." Claimant's wife testified that their older daughter, who is 34, has deterioration of the spine, and she and Claimant make her $300/month trailer payment. Their 33-year old daughter was born with brain tumors, a collapsed lung, and a heart condition. In addition, she was dropped at the hospital in 1971, which caused tumors and epileptic seizures to develop. Claimant and his wife provide her $200-$300 a month, so she has a place to live, and

her medication. The couple does not claim either daughter as a dependent for income tax purposes.

Claimant testified that he has problems with his head, back, legs, and knees in addition to his Black Lung. He sometimes cries in the night for Ben Gay because of the pain he's in. He sees Dr. Patel, who has prescribed pills and nebulizer treatments that Claimant takes twice a day. Claimant's wife testified that at times her husband worked in ice water from the chest down. His boots would have ice in them and his feet would be numb. She'd have to clean the black coal dust out of his ears without damaging the eardrum. She further testified that Claimant has a chronic lung condition and sleeps in a Craftmatic adjustable bed to remain elevated. He's on oxygen at night, uses an inhaler, a Nebulizer four times a day, and takes heart medication. In 1974, Claimant was taken from Westmoreland to the hospital and was given a "survival shot." In addition to Dr. Patel, Claimant also sees Dr. Van Dan for his heart. Claimant's wife stated that her husband has undergone four heart catheterizations, that he is on Trycor, Zocor, arthritis medicine, and three inhalers. She testified that he spends his day watching television and enjoying his pets and livestock.

Claimant testified that he smoked about half a year when he was about 18 or 19 years old. He denied telling Dr. Daniel that he smoked for ten years. He stated that he told one physician that he smoked one to two cigars in his entire life but the doctor wrote that he had a history of smoking 3-4 packs of cigarettes a day. He explained that he could not smoke and work in the mines at the same time. Claimant's wife confirmed that he smoked only about a year in the early 1970s.

Length of Coal Mine Employment

Claimant testified that his first coal mine employment was hand loading coal for a Mr. Price for about 2-5 years, loading 18 buggies a day. He next worked at Flat Top Collieries in 21 inches of coal. He estimated that he was there for 4-5 years before working at Beckley Coal for 2-3 years. His next employer was Vince Calvert for a year or two. From there, he worked for Wyco for 2-3 years, followed by Rice Branch, where he worked about 3 years. It was while working for Westmoreland in Rice Branch, West Virginia that Claimant suffered one of his electrocutions. Still, he returned to work, this time for J & E Mining for three to five months. Claimant testified that he has a total of over 32 years of coal mine employment. His last job for Westmoreland was as a tailpiece man, buggy man, and miner shoveler. He put up and took down belts and carried heavy supplies. Almost all of his work was underground. Claimant last worked in 1999, when he found he could no longer handle the job. His wife and daughter found him crawling home. He has not worked since.

Claimant's wife testified that Claimant worked as a coal miner prior to their marriage. He began as a coal miner at the age of 11 in a punch mine called Pig Shin. He worked at Beckley Coal for several years prior to their marriage, and then for Calvert, Amigo Smokeless, and Westmoreland. Claimant suffered a mental breakdown at Westmoreland, and the company would not let him return to work, but Amigo

Smokeless took him back for about six months. He then worked for his late brother at Egeria for six years on a trial basis but there are no records of this employment, because Claimant's late brother "gave [ ] his six years to a nephew." Tr. 49. She further stated that other than a few months of construction work for Gary Slusher, owner of Beckley Building Services, Claimant worked only as a coal miner.

Claimant testified on cross examination that he worked for J&E Mining, known also as Egeria, for 2-3 months at a time, then he'd get sick and be in the hospital for a while, and return for another few months. This pattern continued for about six years, according to him. Claimant's wife, however, estimated that he worked a total of three years for J&E Mining but not consistently. His last coal mine employment, according to Claimant's wife, was in 1999 for Raleigh Mine Supply, a belly mine.

The hearing testimony alone makes it very difficult to determine a length of coal mine employment. To complicate matters further, Claimant alleged 20-30 years of coal mine employment on his application for benefits. DX 5. By comparison, in his 1985 claim, he alleged 15 ½ years, and in his 1996 claim, he alleged 18 ½ years of coal mine employment. DX 2, 3. Judge Holmes credited Claimant with at least 15 years of coal mine employment.

The Social Security records confirm, at most, seven and one-half years of coal mine employment, as follows:

Employer	Years of Employment
Flat Top Colliery Corp.	1970-71
Beckley Coals Inc.	1971
Calvert Coal Co.	1972
Amigo Smokeless Coal Co.	1972 & 1975
Westmoreland Coal Co.	1972-74
J&E Mining	1979
Mountain Laurel Resources Co.	1981
Teays Mining Inc.	1995

DX 7.

Claimant's Employment History form accounts for 16 years and 5 months of coal mine employment, thus:

Employer	Years of Employment
Flat Top Colliery Corp.	1963-67
Smiley Coal Co.	1967-68
Beckley Coals Inc.	1968-69
Calvert Coal Co.	1970
Westmoreland Coal Co.	1971-74
Amigo Smokeless Coal Co.	1974-79
E&R Mining (same as J&E)	1979

New River Coal	1981
Teays Inc.	March-April 1995
Raleigh Supply	4 months in 1999

DX 6.

Amid the contrary evidence, I choose to credit the Employment History form, taking into consideration Claimant's testimony that he was sometimes not paid as he should have been. Thus, all of his coal mine employment might not have been properly reported to Social Security. Accordingly, I find that Claimant worked as a coal miner for 16 years and 5 months, ending in 1999, and that his last coal mine employer of at least one year was Westmoreland Coal Company.

Dependency

Despite the testimony of Claimant and his wife that their two daughters are dependent upon them, Claimant alleged only one dependent for purposes of augmentation of benefits, his wife. Employer does not contest that Claimant has one dependent. Accordingly, I find that Claimant has one dependent.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The quality standards for chest x-rays and their interpretations are found at 20 CFR § 718.102 (2004) and Appendix A of Part 718. The following table summarizes the x-ray findings available in this case. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR § 718.102(b) (2004).

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[2] If no qualifications are noted for any of

[2]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing

the following physicians, it means that I have been unable to ascertain them either from the record or the NIOSH list. Qualifications of physicians are abbreviated as follows: A= NIOSH certified A reader; B= NIOSH certified B reader; BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray/ reading	Readers' Qualifications (all are doctors)	Reading and Film Quality	Result Concerning Presence of Pneumoconiosis
DX 11 12/06/01 12/06/01	Gaziano B	1/1; p/p/Quality 1	Positive (OWCP's evaluation)
DX 11 12/06/01 01/18/01	Navani B, BCR	Quality 3	Used by District Director for quality reading only[3]
DX 13 12/06/01 04/17/02	Wiot B, BCR	Completely Negative/Quality 2	Negative (Employer's rebuttal of DX 11)
DX 15 4/24/02 5/26/02	Zaldivar B	Negative; evidence of inflammation at left lower lobe/Quality1	Negative (Employer's evaluation)
EX 1 1/19/04 1/26/04	Willis B, BCR	Negative/Quality 1	Negative (Employer's evaluation)

Pulmonary Function Test

Pulmonary function tests (PFT) are performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. If their is greater resistance to the flow of air, there is more severe lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The quality standards for PFTs are found at 20 CFR § 718.103 (2004) and Appendix B. The following chart summarizes the results of the PFTs available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary

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an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] February 20, 2007, found at oalj.dol.gov – then connect to the link titled "Updated B-Reader List." Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www2a.cdc.gov/drds/breaders/breaders_results.asp.

[3] Used by the District Director (DD) for a quality reading only. This reading was not submitted or mentioned by either party; and thus, I will not consider it other than as a reading for film quality.

test, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2004).

Ex. No. Test Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 15 4/24/02 Zaldivar	52 66”	1.66	3.22	52%	---	Yes	Very poor effort; invalid due to poor cooperation
DX 11 4/11/03 Gaziano	53 66”	2.73	4.02	67%	42	No	Poor cooperation and understanding.
EX 1 1/19/04 Crisalli	54 66”	1.95	2.86	68%	---	No	Dr. Crisalli declared the studies invalid due to varying effort as shown by the extreme variability on the flow-volume curve. Study was stopped during spirometry because of chest pain.

Arterial Blood Gas Studies

Arterial blood gas (ABG) studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The quality standards for arterial blood gas studies are found at 20 CFR § 718.105 (2004). The following chart summarizes the arterial blood gas studies available in this case. A “qualifying” arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically not advisable. 20 CFR § 718.105(b) (2004).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 11	12/6/01	Gaziano	29	62	Yes	Found acceptable by Dr. Ranavaya. DX 11.
DX 15	4/24/02	Zaldivar	35	63	Yes	
EX 1	1/19/04	Crisalli	36	71	No	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis is a substantially contributing cause of the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in 20 CFR § 718.201. See 20 CFR § 718.202(a)(4) (2004). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2004).

Where total disability can not be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2004). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2004). Quality standards for reports of physical examinations are found at 20 CFR § 718.104 (2004). The record contains the following medical opinions relating to this case.

Dr. Gaziano

Claimant was examined by Dr. D. Gaziano on behalf of the Office of Workers' Compensation Board on December 6, 2001. DX 11. Dr. Gaziano considered 33 years of coal mine employment, all underground as a belt man and general inside laborer, family history, a medical history significant for pneumonia, wheezing, arthritis, heart disease, a collapsed lung, and back injuries, and a history of never smoking. Claimant complained of a productive cough, wheezing, dyspnea, hemoptysis, chest pain,

orthopnea, ankle edema, headaches, and paroxysmal nocturnal dyspnea. Physical examination was normal. Dr. Gaziano considered the results of an x-ray, a pulmonary function study[4], and a blood gas study. He diagnosed coal workers' pneumoconiosis due to coal mining and opined that Claimant is disabled from coal mine work.

In a letter dated May 19, 2003, Dr. Gaziano revised his opinion based on Claimant's coal mine employment history of only a little over five years underground. He opined that the x-ray findings consistent with pneumoconiosis are not related to the Claimant's very limited coal mine work.

Dr. Zaldivar

For the Employer, Dr. Zaldivar examined the Claimant on April 24, 2002 and provided a report dated May 28, 2002. DX 15. He took a sketchy occupational history of apparently 18-19 years of coal mine employment until 1981, working jobs such as belt man, general laborer, shuttle car operator, and miner and loader helper, as well as family and medical histories significant for electrocution with brain injury and heart disease. He noted that Claimant smoked two cigars four years ago. He considered symptoms of trouble breathing for a long time, using oxygen at night, wheezing for about two years, coughing with sputum in the morning, orthopnea, and occasional swelling of the feet and ankles. Physical examination showed clear lungs without wheezes, crackles, or rales. Dr. Zaldivar administered a chest x-ray, pulmonary function study, and blood gas study. He diagnosed heart disease and a history of brain damage which might explain the lack of cooperation and inability to answer questions sensibly. His examination of the lungs was normal. Dr. Zaldivar found no evidence of pneumoconiosis. He noted a high carboxyhemoglobin level equivalent to smoking one pack of cigarettes a day.

Dr. Zaldivar also reviewed additional evidence, including interrogatories regarding coal mining duties, a questionnaire as to length of coal mine employment, and medical evidence dating from October 1996 to December 2001. He found these records agreed in all respects with previous records he had reviewed. He concluded that Claimant never cooperated in any of the breathing tests, that his lack of cooperation prevented any exercise blood gas studies, and that Claimant has continued to smoke in spite of his assertion to the contrary. Dr. Zaldivar attributed the hypoxemia at rest to smoking with mucous pluggings of the airways. He believed it would resolve with exercise. He found no evidence of pneumoconiosis or any dust disease of the lungs. Neither did he find any evidence of any pulmonary impairment. He noted that several of the PFTs showed excellent values even with poor cooperation. In Dr. Zaldivar's opinion, Claimant is fully capable of performing his usual coal mine work from a pulmonary standpoint. This opinion would not change even if Claimant were found to have pneumoconiosis.

[4] Because the December 6, 2001 PFT was deemed invalid by both Dr. Gaziano and Dr. Renn, who is board certified in internal medicine and pulmonary disease, DX 12, Claimant was entitled to undergo another, valid PFT. This occurred on April 11, 2003.

Dr. Zaldivar provided a supplemental report dated June 30, 2004. EX 2. These consisted of his own reports of April 4, 1991, October 12, 1991, January 19, 1999, March 28, 2002, the April 24, 2002 x-ray, Dr. Crisalli's January 19, 2004 medical evaluation, Dr. Willis's reading of the January 19, 2004 x-ray, and the ABG of January 19, 2004. He found no evidence to justify a diagnosis of CWP or any dust disease of the lungs. He found no evidence of any pulmonary impairment or disability, noting a lack of cooperation on the PFTs. He opined that the resting hypoxemia is not in itself an indication of disability. Finally, he averred that from a pulmonary standpoint, Claimant is fully capable of performing his usual coal mining work or work requiring similar exertion.

Dr. Zaldivar was deposed on May 9, 2005. EX 4. He provided his qualifications; he is board certified in internal medicine, pulmonary diseases, sleep medicine, and critical care medicine, as well as being a B-reader. He deposed that Claimant was a poor historian in all respects. He reiterated the opinions set forth above.

Dr. Crisalli

For the Employer, Dr. Crisalli examined the Claimant on January 19, 2004. EX 1. Dr. Crisalli is board certified in internal medicine and pulmonary diseases. He considered a history as a non-smoker, and 30 years of coal mine employment, lastly on the belt line and shoveling coal. Dr. Crisalli set forth the exertional requirements of these jobs. Claimant reported symptoms of shortness of breath since 1975, now even when walking through the house, a daily cough and sputum production since 1975, chest pain, occasional ankle edema, orthopnea, and paroxysmal nocturnal dyspnea. The Claimant's medical history was significant for coronary artery disease, emphysema, multiple injuries during a rock fall, electrocution, brain injuries, and musculoskeletal injuries. Physical examination revealed diminished breath sounds bilaterally but clear lung sounds. Dr. Crisalli also reviewed the results of an x-ray, pulmonary function study, and blood gas study. Dr. Crisalli noted that Claimant was unable to complete the pulmonary function study because he complained of chest pain. While Claimant initially refused to go to the emergency room, he later did go and the emergency room physician informed Dr. Crisalli that Claimant would probably need a cardiac evaluation. Dr. Crisalli did not know if such an evaluation followed.

Dr. Crisalli also reviewed medical data from March 31, 1991 to April 24, 2002. Dr. Crisalli did not find sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis or any chronic dust disease of the lung caused by, significantly related to, or substantially aggravated by coal mine employment. He detected a mild degree of hypoxemia that he related to the Claimant's cigarette smoking and overweight state. He also opined that Claimant may have a very mild degree of pulmonary functional impairment but added that it was not sufficient to prevent him from performing his usual coal mine work. His opinion would not change even if Claimant were found to have CWP.

Dr. Crisalli was deposed on May 23, 2005. EX 5. He reiterated his findings based on his examination of Claimant. He reviewed Dr. Gaziano's letter attributing only

five years of coal mine employment to Claimant. He did not find that to be a significant coal mine dust exposure history. He testified that Claimant informed him that he had never smoked, but he noticed some variation of that in the other material he reviewed, namely a half pack of cigarettes per day for an unknown length of time, according to an earlier hearing transcript[5], and an elevated carboxyhemoglobin level at Dr. Zaldivar's examination. Thus, Dr. Crisalli assumed some smoking history but of unknown duration.

Dr. Crisalli considered Dr. Gaziano's positive x-ray reading and Dr. Wiot's negative rereading of the same film. He relied on Dr. Wiot's assessment given his credentials. Even assuming that the PFT he administered were valid, Dr. Crisalli deposed that it indicated a very mild obstruction at most. He did not have an explanation as to why Claimant's pO2 was worse on the two earlier examinations by Drs. Gaziano and Zaldivar but showed improvement during his evaluation. Dr. Crisalli reiterated his conclusions that Claimant does not have pneumoconiosis and is not totally disabled from a pulmonary perspective. He added that Claimant's coronary artery disease is not a result of coal mine employment.

Dr. Patel

Dr. Vishnu A. Patel provided handwritten note on a prescription pad, which is dated December 7, 2005. CX 1. He wrote: "Please be advised [Claimant] is our patient and carries the diagnosis of pneumoconiosis and pleural thickening most likely secondary to previous exposure in coal mines. We are currently monitor[ing] [right upper lung] nodules closely."

DISCUSSION AND APPLICABLE LAW

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248

[5] In fact, at the July 1, 1998 hearing before ALJ Samuel J. Smith, Claimant testified that he had quit smoking but before that "smoked a couple of cigarettes." When confronted by the evidence that one doctor had done a test that showed smoke in his blood, he stated that he had informed that physician that he smoked "sometimes half a pack." He also testified that maybe he smoked a pack a day one time in his life but it lasted no more than a week. He again explained that he didn't have time to smoke because of all his work in the mine. Claimant also testified that he had told Dr. Jabour, in 1997, that he had smoked cigars for a while. The last time he smoked a cigarette was a month or two before the hearing, and he had given them up for good. DX 2, 7/1/98 transcript, pp. 29-31.

At the March 14, 2000 hearing before ALJ Holmes, Claimant testified that he smoked one or two cigarettes after leaving the mine but explained that after an 18-20 hour shift, he didn't have time to smoke. Claimant's wife testified that she couldn't account for when they were not married but that he quit in about 1995 but hadn't completely quit yet, still puffing every once in a while. DX 3, 3/14/00 transcript, p. 32.

(10th Cir. 1990); *Orange v. Island Creek Coal Company*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

Claimant's most recent prior claim was denied after Judge Holmes determined that Claimant failed to establish the existence of pneumoconiosis or total disability. Therefore, in order for Claimant to avoid having his subsequent claim denied on the basis of the prior denial, he must establish one of these elements of entitlement through the newly submitted evidence.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2004).

20 CFR § 718.202(a) (2004) provides that a finding of the existence of pneumoconiosis may be based on evidence from a (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions (not applicable here) described in Sections 718.304, 718.305, or 718.306, or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. In order to determine whether the evidence establishes the existence of pneumoconiosis, I

must consider the chest x-rays and medical opinions – the two categories of evidence applicable in this case. As this claim is governed by the law of the Fourth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a).

Pneumoconiosis is a progressive and irreversible disease. *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

Of the five available x-ray readings in this case, one was considered positive for pneumoconiosis while three were found to be negative. There is also one reading made for quality purposes only. For cases with conflicting x-ray evidence, the regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 CFR § 718.202(a)(1) (2004); *Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-37 (1991).

Readers who are board-certified radiologists and/or B readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). Greater weight may be accorded to x-ray interpretations of dually qualified physicians. *Scheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128, 1-131 (1984). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321; *see Adkins*, 958 F.2d at 52. Finally, a radiologist's academic teaching credentials in the field of radiology may be relevant to the evaluation of the weight to be assigned to that expert's conclusions. *See Worhach v. Director*, *OWCP*, 17 B.L.R. 1-105, 1-108 (1993).

Analysis of X-Ray Studies

The December 6, 2001 x-ray was found positive by Dr. Gaziano, a B-reader. Dr. Wiot, who is both a B-reader and a board-certified radiologist, read this film as

negative for pneumoconiosis. Dr. Navani, also a dually certified reader, adjudged the film quality to be 3, while both Dr. Gaziano and Dr. Wiot felt it was of better quality. I place greater weight on the Dr. Wiot's reading because of his superior credentials for x-ray interpretation. Therefore, I consider this x-ray negative. *Scheckler*, 7 BLR 1-128.

The April 24, 2002 x-ray was found negative by Dr. Zaldivar, a B-reader. The x-ray was not reread. The January 19, 2004 x-ray was found negative by Dr. Willis, a B-reader and board-certified radiologist, and was not reread. Both found the films to be of the best quality. I find these x-rays negative for pneumoconiosis based on the credentials of the readers and the uncontroverted readings. Accordingly, I find that the x-ray evidence fails to establish, by a preponderance of the evidence, the existence of pneumoconiosis.

Analysis of Medical Opinions

Medical Opinion Guidance

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). A physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co*., 6 B.L.R. 1-1182, 1-1184 (1984). An opinion may be given little weight if it is equivocal or vague. *Griffith v. Director, OWCP*, 49 F.3d 184, 186-187 (6th Cir. 1995); *Justice v. Island Creek Coal Co*., 11 B.L.R. 1-91, 1-94 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236, 1-239 (1984).

The qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWC*P, 14 B.L.R. 1-2, 1-6 (1989). However, a judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration in … weighing … the medical evidence …"

Tedesco v. Director, OWCP, 18 B.L.R. 1-103, 1-105 (1994). Factors to be considered in weighing evidence from treating physicians include the nature and duration of the relationship, and the frequency and extent of treatment. In appropriate cases, a treating physician's opinion may be given controlling weight, provided that the decision to do so is based on the credibility of the opinion "in light of its reasoning and documentation, other relevant evidence and the record as a whole." 20 CFR § 718.104(d) (2004). The Sixth Circuit has interpreted this rule to mean that:

> in black lung litigation, the opinions of treating physicians get the deference they deserve based on their power to persuade … For instance, a highly qualified treating physician who has lengthy experience with a miner may deserve tremendous deference, whereas a treating physician without the right pulmonary certifications should have his opinions appropriately discounted. The case law and applicable regulatory scheme make clear that ALJs must evaluate treating physicians just as they consider other experts.

Eastover Mining Co. v. Williams, 338 F.3d 501, 513 (6th Cir. 2004) (citations omitted).

Balancing Conflicting Medical Opinions

Before addressing the medical opinions, I feel I must address the evidence concerning Claimant's smoking history. Reports given to physicians and Claimant's testimony at three different hearings are somewhat at odds with the results of carboxyhemoglobin tests. At the 1998 hearing, Claimant testified that he smoked a couple of cigarettes but had quit. In 2000, he testified that he smoked one or two cigarettes after his shifts, and his wife stated that although he had pretty much quit in 1995, he still puffed every once in a while. At the 2006 hearing, Claimant testified that he smoked about half a year at the age of 18 or 19, and his wife testified that he smoked about a year in the early 1970s. The most recent testimony is clearly at odds with the testimony from the earlier two hearings. When combined with Dr. Zaldivar's testimony that the carboxyhemoglobin level he measured indicated recent smoking equivalent of a pack of cigarettes a day in 2002, I conclude that neither Claimant nor his wife provided credible testimony regarding his smoking history. I note, however, that despite the unclear extent and nature of Claimant's smoking history, any variation does not affect the weight I place on the medical opinions.

The Claimant has also failed to meet his burden of proof to show – by medical opinion evidence – that he has pneumoconiosis. After weighing all of the medical opinions of record, I resolve this conflict by according greater probative weight to the opinions of Drs. Crisalli and Zaldivar for the reasons stated below.

Dr. Gaziano and Dr. Patel diagnosed pneumoconiosis while Drs. Zaldivar and Crisalli did not. Dr. Patel's opinion, unfortunately, is not supported by any objective evidence in the record. He did not explain how he came to the diagnosis—x-ray, physical examination, coal mine employment history, or symptoms. Thus, I do not

consider his opinion to be well reasoned and documented, *Fuller v. Gibraltar Corp.*, 6 BLR 1-1291 (1984), and I discount his opinion.

Dr. Gaziano's opinion is based on his x-ray reading, yet that reading was reread as negative by a better-qualified reader, and all later x-rays were also found to be negative. His physical examination of Claimant revealed no pulmonary abnormalities. He also clearly relied upon a lengthy coal mine employment history, as evinced by his follow-up letter, in which he stated that if Claimant had only five years of coal mine employment, the pneumoconiosis found on x-ray was not due to coal mine employment. While I have credited Claimant with more than five years but fewer than the 33 years Dr. Gaziano initially relied upon, it is clear that Dr. Gaziano's diagnosis of pneumoconiosis was based upon the x-ray and coal mine employment history. An opinion based on nothing more may be given less weight. *Lafferty v. Cannelton Industries, Inc.*, 12 BLR 1-190 (1989); *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). For this reason, I place less weight on Dr. Gaziano's opinion.

The opinions of Drs. Zaldivar and Crisalli are well documented and reasoned. *Perry v. Director, OWCP*, 9 BLR 1-1 (1986). They are consistent with the overall x-ray evidence. Both physicians conducted physical examinations that showed clear lungs. Furthermore, both doctors share excellent credentials in the field of pulmonary diseases. *Scott v. Mason Coal Co.*, 14 BLR 1-38 (1990). Consequently, I place greater weight on their opinions. Therefore, I conclude that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(4). Further consideration of all the medical evidence under § 718.202(a) leads me to also conclude that the x-ray evidence combined with the most logical and credible medical opinions fails to establish the existence of pneumoconiosis.

Pneumoconiosis Arising out of Coal Mine Employment

In order to be eligible for benefits under the Act, Claimant must prove that pneumoconiosis arose, at least in part, out of his coal mine employment. § 718.203(a). Because Claimant established 16 ½ years of coal mine employment, he would be entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of coal mine employment if he had established the existence of pneumoconiosis.

Total Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2004), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment. 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2004). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR

§ 718.204(b) and (d) (2004). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2004); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no evidence in the record that the Claimant suffers from cor pulmonale. Thus, I will consider pulmonary function studies, blood gas tests, and medical opinions.

Pulmonary Function Tests

There are three pulmonary function studies to consider. Only the April 24 2002 study produced qualifying values. However, Claimant provided very poor effort, according to the report, and Dr. Zaldivar, who administered the test, declared it invalid due to poor cooperation. Neither the April 11, 2003 nor the January 19, 2004 studies yielded qualifying values despite poor cooperation on both tests. In fact, Dr. Crisalli found the 2004 study he conducted invalid. Based on the apparently valid study of April 11, 2003 and the non-qualifying values on the invalid January 2004 study, I find that Claimant has not established total disability pursuant to § 718.204(b)(2)(i).

Arterial Blood Gas Studies

Of the three blood gas studies, the December 6, 2001 and April 24, 2002 test produced qualifying values, and the former was found acceptable by Dr. Ranavaya. However, I find most probative the fact that the most recent study by almost two years did not yield qualifying values. More weight may be accorded to the results of a recent blood gas study over a study that was conducted earlier. *Schretroma v. Director, OWCP*, 18 BLR 1-17 (1993). Accordingly, I find that the evidence fails to establish, by a preponderance of the evidence, that Claimant is totally disabled pursuant to § 718.204(b)(2)(ii).

Medical Opinions

Dr. Gaziano opined that Claimant is disabled from coal mine work, but he did not express that the disability was total. He did not assess the degree of disability. Therefore, I do not consider this equivalent to a finding of total disability. Dr. Patel did not address this issue. Dr. Zaldivar opined that Claimant is capable of performing his usual coal mine employment from a pulmonary standpoint, and Dr. Crisalli stated that Claimant does not have a pulmonary impairment sufficient to prevent him from performing his usual coal mine work.

I place great weight on the opinions of both Dr. Zaldivar and Dr. Crisalli, because they are supported by the valid, objective medical tests, as well as their physical examinations of Claimant. Furthermore, both physicians had the opportunity to review all the medical evidence of record, in addition to their own examinations, thus providing them with a broad base of data from which to draw their conclusions. Consequently, I find that the medical opinion evidence does not establish total disability pursuant to

§ 718.204(b)(2)(iv). After considering all the evidence under § 718.204(b)(2), I find that the medical opinion evidence, as supported by the valid PFT and ABG evidence, fails to establish, by a preponderance of the evidence, that Claimant is totally disabled.

Summary

In the instant case, Claimant has not established the existence of pneumoconiosis pursuant 20 CFR § 718.202(a) or total disability pursuant to § 718.204(b)(2). Consequently, I find that Claimant has not demonstrated that one of the applicable conditions of entitlement has changed since the denial of his last claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has failed to meet his burden to establish the existence of pneumoconiosis or total respiratory disability. Consequently, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. See Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by the Claimant on September 19, 2001, is hereby DENIED.

A

WILLIAM S. COLWELL
Administrative Law Judge

Washington, D.C.
WSC:AS

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your

appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).